

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

01693

CERTIFICATE OF DEATH

Reg. Dlat. No. 92

1. PLACE OF DEATH:

County: *Cecil*City or town: *Frederick Del Del*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *46 yrs*

Hospital, institution, or street address where death occurred:

*near Copleton Md.*How long in hospital or institution? *11*

3. (a) FULL NAME

Bertha Biddle

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.) *Aug 34 - 1872*

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

72

5

19

hrs. min.

9. Birthplace

Cecil Co Md

(Town, county, and state)

10. Usual occupation

Horsewoman

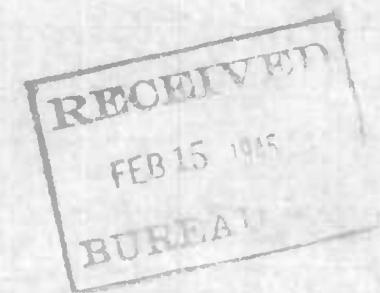
11. Industry or business

George Biddle

FATHER

MOTHER

FATHER



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

01604

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

Cecil
CountyVeterans Administration, Perry Point, Md.
City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs. 8 mo. 8 da.

Hospital, institution, or street address where death occurred:

Veterans Administration Facility, Perry Point

How long to hospital or institution? Same as above Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State County Prince Georges

Berwyn

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

W.W. I

2.(a) If veteran, name war.....

3. (a) FULL NAME

BRYAN, Orlando

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced
Male White Married6.(b) Name of husband or wife..... Mary Bryan (Maiden name
UNKNOWN) Unknown

7. Birth date of deceased (mo., day, yr.) May 30, 1886

8. AGE: Years Months Days If less than one day
58 8 12 - hrs. - min.

Trenton, N.C.

9. Birthplace (Town, county, and state)

10. Usual occupation Farm helper

11. Industry or business

12. Name John W. Bryan

13. Birthplace Jones County, N.C.

14. Maiden name Nancy Koonce

15. Birthplace Jones County, N.C.

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal Date thereof 2-13-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. Feb. 13, 1945 - Irene E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1945 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 1934 to Feb. 11 1945

and that I last saw him alive on February 11 1945

Immediate cause of death Epilepsy 30 years DURATION

Due to

Due to

Other conditions Psychosis with epileptic deter-
operation oritis sclerosis, general and 11 yrs

Cerebral (Include pregnancy within 3 months of death) 11 yrs.

Major findings of operations Date of op. -

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury Injured at work? -

23. SIGNATURE J. E. Reeselius
L. TROLLINGER, Lt. Col., M.C., C.M.P.C. the Director
Address Perry Point, Md. Date signed 13-45

RECEIVED

MAR 5 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 92

Dr. Betty
01605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 mo

Hospital, institution, or street address where death occurred:

#50 Hollingsworth Manor.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Wh. Single.

6. (b) Name of husband or wife

6. (c) If alive, give age years

T. Birth date of deceased (mo., day, yr.) Dec. 18, 1944

8. AGE:

Years

Months

Days

If less than one day

1 28 hrs. min.

9. Birthplace

Elkton, Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name

Charles Burkins

MOTHER

13. Birthplace

Rising Sun, Md.

14. Maiden name

Catherine Gaspert.

15. Birthplace

Sellsville, Pa.

16. Informant

Charles Burkins

Address

Elkton, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Rising Sun, Md.

Location

Rising Sun, Md.

18. Funeral director

M.W. Pippin

Address

Elkton, Md.

19. Feb 19 1945

(Date rec'd by registrar)

H. Frazer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. #50 Hollingsworth Manor

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 16 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 14

1945

to

Feb 16

1945

and that I last saw him alive on

Feb 16

1945

Immediate cause of death

Bronchitis pneumonia

Due to

Bronchitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

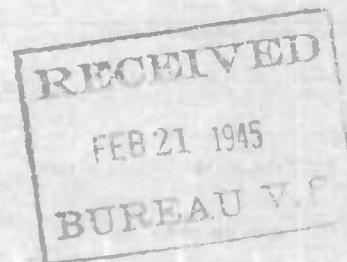
23. SIGNATURE

John Burkhels, M.D.

M. D. or other

Address

Elkton, Md. Date signed Feb 16 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01606

CERTIFICATE OF DEATH

Reg. Dist. No. 96

M
The correct age
is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County. CecilCity or town. Bainbridge, Maryland.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 days
Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCen, Bainbridge, Maryland.How long in hospital or institution? 2 days

3. (a) FULL NAME

Hendley Glennis BURSON4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced SINGLE6. (b) Name of husband or wife not married7. Birth date of deceased (mo., day, yr.) 9/27/26 8. (c) If alive, give age years8. AGE: Years 18 Months 4 Days 25 If less than one day hrs. min.9. Birthplace Rock Mills, Alabama
(Town, county, and state)10. Usual occupation US Navy

11. Industry or business

12. Name William Jewell BURSON13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant US Naval Hospital, NavTraCen
Bainbridge, Maryland.Address Re Removal Date thereof Feb. 24, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)17. Cemetery or crematory To Hammert & Groover Funeral HomeLocation Lagrange, Georgia18. Funeral director Lee A. Patterson & SonAddress Perryville, Md.19. Feb. 24, 1945 - June E. Daugherty
(Date rec'd by registrar) Registrat2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Georgia County TroupCity or town Lagrange
(If outside city or town limits, write RURAL and give nearest town)Street No. 200 Addie Street
(If rural, give LOCATION)2.(a) If veteran, name war WORLD WAR II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 February, 1945 18. at 11:55PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

20 February, 1945 19. to 22 February 1945 19.

and that I last saw him alive on 22 February, 1945 19.

Immediate cause of death.

POISONING, THERAPEUTIC, ACUTE (Sulfa-
diazine, prophylactic.)

DURATION

5 days

Due to.

Due to.

Other conditions Pneumonia, lobar 3 days

(Include pregnancy within 3 months of death)

Major findings of operations.

Exfoliative dermatitis, bronchitis and oesophagitis

Autopsy results gut, lobar pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury J.B. Black Injured at work?23. SIGNATURE J.B. Black Lieut. (MC) USNM. D. or other US Naval Hospital, NavTraCenAddress Bainbridge, Md. Date signed 2/22/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01607

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County CecilCity or town Elkton (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 minutesHospital, institution, or street address where death occurred: Union HospitalHow long in hospital or institution? 5 minutes

3. (a) FULL NAME

Barth Anna Case4. Sex Female 5. Color of face white 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Dec 17, 1945 6. (c) If alive, give age..... years8. AGE: Years 1 Months 27 Days If less than one day hrs. min. 9. Birthplace Elkton, Md. (Town, county, and state)10. Usual occupation None11. Industry or business FATHER 12. Name James R. Case 13. Birthplace Felton Del.MOTHER 14. Maiden name Elizabeth Scott 15. Birthplace Chester, Pa.16. Informant Elizabeth CaseAddress Elkton P.D. 1 Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 15, 1945 (month) (day) (year)Cemetery or crematory Boggsboro ChapelLocation Tent Co Park Del.18. Funeral director A. W. PipkinAddress Elkton, Md.19. Feb 15 1945 Date rec'd by registrar TH Fraser Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County New CastleCity or town Burial near Elkton (If outside city or town limits, write RURAL and give nearest town)Street No. P.D. 1 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 45 a.m. 8:50 m21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 19 45 to Feb 13 19 45and that I last saw her alive on Feb 13 19 45Immediate cause of death Bronchitis pneumonia

DURATION

Due to Bronchitis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

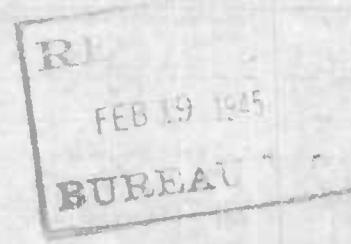
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE HeberdaleM. D. or other MDAddress Elkton, Md. Date signed 2/16/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

01608

CERTIFICATE OF DEATH

Reg. Diet. No. 96

1. PLACE OF DEATH:
County..... Veterans Administration (CECIL)
City or town..... Perry Point, Md. (COUNTY)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? 2 days

3. (a) FULL NAME

CHRYSSTAL, Edward T.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6. (b) Name of husband or wife.....

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1887

8. AGE: Years	Months	Days	If less than one day
57	3	19	- hrs. - mts.

9. Birthplace..... Hutton, W. Va. (Town, county, and state)

10. Usual occupation..... Unknown

11. Industry or business.....

12. Name	Michael J. Chrystal
13. Birthplace	Oakland, Md.

14. Maiden name	Margaret Joyce
15. Birthplace	Terra Alta, W. Va.

16. Informant..... Hospital Records

Address Veterans Administration, Perry Point,

17. Removal..... Cemetery or crematory..... Date thereof.....

(Burial, cremation, or removal. Which?) (month) (day) (year)

Catholic Cemetery

Location..... Terra Alta, W. Va.

18. Funeral director.....

Address Havre de Grace, Md.

19. Date rec'd by registrar.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W. Va. county..... Tucker County

City or town..... Davis (If outside city or town limits, write RURAL and give nearest town)

Street No..... None

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

-

MEDICAL CERTIFICATION

February 2

1945 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1945 to February 2 1945

and that I last saw h. 1m alive on February 2 1945

Immediate cause of death.....

Cerebral Hemorrhage, with Hemiplegia right

DURATION

9 hrs.

Due to.....

Due to.....

Other conditions..... Psychosis due to alcoholism, acute

3 weeks

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE: E. TROLLINGER, Lt. Col., M.C., Col. or other M.C.

Clinical Director, Veterans Administration, Perry Point, Md.

Date signed 2-3-45

Address.....

Administration, Perry Point, Md.

LETTER TO THE HAVING STATE GUARDIAN

LETTER TO THE HAVING STATE GUARDIAN

LETTER TO THE HAVING STATE GUARDIAN

RECEIVED

MAR 5 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18609

01609

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil
 County: Elkton R.D. 1
 City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred: Neuro Hospital

How long in hospital or institution? 3 Days

3. (a) FULL NAME Rose Cross

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Orlando G Cross

7. Birth date of deceased (mo., day, yr.) Dec 2 1871 8. (c) If alive, give age 74 years

8. AGE: Years 73 Months 2 Days 7 It less than one day hrs. 0 min. 0

9. Birthplace Germany (Town, county, and state)

10. Usual occupation House wife

11. Industry or business -

12. Name no information

13. Birthplace Germany

14. Maiden name no information

15. Birthplace Germany

16. Informant Orlando G Cross

Address Elkton R.D. 1

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb 12 1945

(month) (day) (year)

Cemetery or crematory Elkton Cemetery

Location Elkton Md

18. Funeral director J. W. Pippin

Address Elkton Md

19. Date rec'd by registrar Feb 12 1945 J. R. Fraser Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Cecil

City or town Elkton R.D. 1 (If outside city or town limits, write RURAL and give nearest town)

Street No. 0 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1945 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7 1945 to Feb. 9 1945 and that I last saw her alive on Feb. 9 1945

Immediate cause of death Concussion of Brain

Due to Fall (accident)

Due to

Other conditions Fractured left shoulder

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb 12 1945

Where did injury occur? R.D. #1 (City or town) (County) Cecil (State) Md.

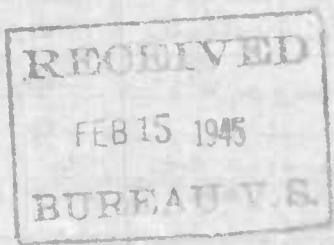
Injured at home, farm, industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE James J. Lathem M. D. or other

Date signed Feb 12 1945

Address Elkton



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

CERTIFICATE OF DEATH

01610 95
Reg. Dist. No.

1. PLACE OF DEATH:

Cecil

County

Outside Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Martha J. Davidson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

John Davidson

7. Birth date of deceased (mo., day, yr.)

Feb. 3, 1868

6. (c) If alive, give age

75

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

North East, Cecil Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Cecil

City or town

Outside Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 4 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

19.

Immediate cause of death

Coronary
Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

Cecil County

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 129

01611

CERTIFICATE OF DEATH

Reg. Dist. No.

9C

1. PLACE OF DEATH:

CECIL

County

Bainbridge, Maryland

(If outside city or town limits, write RURAL and give nearest town)

2 mos. 9 days

How long in above place of death?..... Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCen, Bainbridge, Md.

4 days

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Pennsylvania

County

Philadelphia

City or town

(If outside city or town limits, write RURAL and give nearest town)

2555 S. 61st., St.,

Street No. (If rural, give LOCATION)

WORLD WAR II

2.(a) If veteran, name war.....

3. (a) FULL NAME

DONNELLY, James Edward, Jr.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife.....

Not married

7. Birth date of deceased (mo. day, yr.) 6.(c) If alive, give age..... years

4/18/20

8. AGE: Years Months Days If less than one day

24

9

16

hrs. min.

9. Birthplace.....

Philadelphia, Penna.,

(Town, county, and state)

10. Usual occupation.....

US NAVY

11. Industry or business

12. Name..... James Edward Donnelly, Sr.,

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... US Naval Hospital NavTraCenter

Address..... Bainbridge, Maryland

17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof..... Feb 5 1945
(month) (day) (year)

Cemetery or crematory.....

Location.....

Philadelphia, Pa.

18. Funeral director.....

Address.....

J. E. Patterson & Son

Perryville, Md.

19. Date rec'd by registrar..... Feb 5, 1945. Name & Day of week.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3 February 19 45, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 January 19 45, to 3 Feb. 19 45

and that I last saw h. im alive on 3 February 19 45

Immediate cause of death..... Peritonitis

General, primary, pneumococcal

DURATION

5 days

22. Subsequent to catarrhal fever, acute.

14 days

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... Peritonitis, general, primary

PHYSICIAN: Please underline the cause to which death should be charged statistically.

23. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

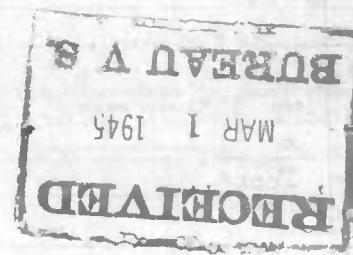
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Harry C. OARD

Address..... U. S. Naval Hospital, Bainbridge, Md.

Date signed..... Feb. 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01612

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

CECIL
County
VETERANS ADMINISTRATION, PERRY POINT, MD.

City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months, 9 days

Hospital, institution, or street address where death occurred:

VETERANS ADMINISTRATION, PERRY POINT, MD.

How long in hospital or institution? SAME AS ABOVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

D. C.

State
County

Washington

City or town
(If outside city or town limits, write RURAL and give nearest town)

903 F Street, N.W.

Street No.
(If rural, give LOCATION)

WW I

✓

2.(a) If veteran, name war

3. (a) FULL NAME

DORSEY, Roland C.

3. (b) Social Security Number

0 -

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Separated

6.(b) Name of husband or wife Mrs. Isabel (Maiden name

unknown)

6.(c) If alive, give age Unknown years

7. Birth date of deceased (mo., day, yr.) November 16, 1896

8. AGE: Years Months Days If less than one day
48 3 4 - hrs. - min.9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

12. Name Edward F. Dorsey

13. Birthplace Unknown

14. Maiden name Gertrude Amanda

15. Birthplace Unknown

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal Date thereof 2-22-45
(Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Pennington & Son, Havre de Grace,

Address Maryland

19. Date rec'd by registrar A. J. E. Prellwitz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2d. DATE OF DEATH February 20 1945 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 11 1944 to Feb. 20 1945

and that I last saw h. im alive on February 20 1945

Immediate cause of death Cerebral Hemorrhage 4 Da. DURATION

Due to Cerebral Arteriosclerosis Over 1 yr.

Due to

Other conditions Psychosis with organic brain disease, cerebral thrombosis Over 1 yr.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. -

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

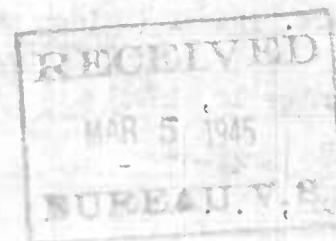
Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE J. E. Prellwitz
TROLLINGER, Lt. Col., M.C. Clinton C. Toller

rector, Veterans Administration Address Perry Point, Md. Date signed 2-21-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

OCECIL
City.....BAINBRIDGE MARYLAND
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

1 month

How long in above place of death?.....

Hospital, Institution, or street address where death occurred: US Naval Hosp.

Naval Training Center, Bainbridge, Md.

How long in hospital or institution?..... 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

PENNA

State..... HARRISBURG County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No. 4601 BETTY STREET

(If rural, town or city)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Ray Billett ESHENOUR

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.) 12 June, 1917

8. AGE: Years Months Days If less than one day

27 8 0 hrs. min.

9. Birthplace..... HARRISBURG, PENNSYLVANIA

(Town, county, and state)

10. Usual occupation..... US NAVY

11. Industry or business

MOTHER FATHER 12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... US NAVAL HOSPITAL, NAV TRA CEN

BAINBRIDGE, MARYLAND

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb. 14, 1945

(month) (day) (year)
Cemetery or crematory To S.S. Fackler Funeral Home
Location Harrisburg, Pa. 1312 Derry St.

18. Funeral director..... Lee A. Patterson & Son

Address Perryville, Md.

19. (Date rec'd by registrar) 2/14/45 Name E. Daugherty

3. (b) Social Security Number

MEDICAL CERTIFICATION

12 February, 1945 7:45 P.M.

20. DATE OF DEATH 10 Feb. 1945 to 12 Feb. 1945
and that I last saw h.s.m. alive on 12 Feb. 1945

Immediate cause of death.....

Splenomegaly

Due to..... Streptococcus hemolyticus

Due to.....

Other conditions..... Fibro-purulent pleurisy
Pericarditis acute

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE PENNA

HARRISBURG M. D. or other

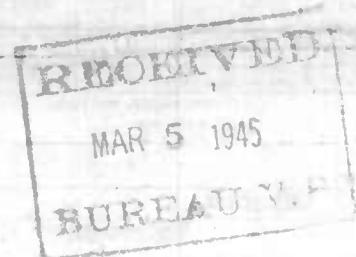
Address 18 Naval Hosp. Bainbridge, Md. Date signed 13 Feb 1945

TELEGRAM TO TENNESSEE STATE GUARDIAN

TELEGRAM TO STATE GUARDIAN

4 2417

4 2417 220000Z MAR 5 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

01614

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County

Rural Port de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Taylor Hughes

4. Sex

Female

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Amos H. Hughes

7. Birth date of deceased (mo. day, yr.)

Sept. 11, 1864

6. (c) If alive, give age years

8. AGE:

80 | 5 | 7 | If less than one day

hrs. min.

8. Birthplace

Harford Co. Md.

(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

John M. Macklear

FATHER

12. Name

John M. Macklear

13. Birthplace

Del.

MOTHER

14. Maiden name

Elizabeth Davies

15. Birthplace

Wilmington Del.

16. Informant

Mrs. Esther M. Hopkins

Address

Harford Co. Md. R. D. #2

17. Burial

Date thereof

Feb 21, 1945

(month) (day) (year)

(Burial, cremation, or removal, which)

Cemetery or crematory

Rock Run

Location

Harford Co. Md.

18. Funeral director

T. P. Madison Mitchell

Address

Harford Co. Md.

19. Date rec'd by registrar

74 20 1945 - Ira E. Daugherty

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. Harford

City or town

Rural Harford

Street No.

Rural Harford

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 19 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan. 15, 1945, to Feb. 15, 1945, and that I last saw her alive on Feb. 6, 1945.

Immediate cause of death

Hepatitis Myocarditis

Due to

Died to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

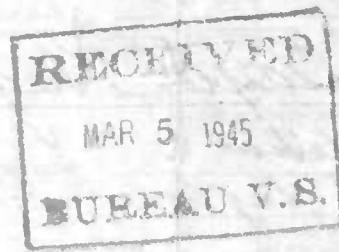
23. SIGNATURE

B. Johnson M. D.

M. D. or other

Date signed 2/19/45

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-15

01615

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... CecilCity or town..... Principio Furnace, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yearsHospital, institution, or street address where death occurred: Principio Furnace, Maryland

How long in hospital or institution?.....

3. (a) FULL NAME

William Norris Jackson

4. Sex Male 5. Color or race White 6. (u) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Ella Fish Jackson7. Birth date of deceased (mo., day, yr.) Jan. 13, 1888 6. (c) If alive, give age ? years8. AGE: Years 57 Months 0 Days 30 If less than one day hrs. min.9. Birthplace Principio Furnace, Cecil, Md.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Tourist Camp12. Name Walter T. Jackson13. Birthplace Principio Furnace, Cecil Co., Md.14. Maiden name Nellie Moore15. Birthplace Harford Co., Md.16. Informant Debbie JacksonAddress Principio Furnace, Md.17. Burial Burial Date thereof Feb. 15, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St MarksLocation Perryville, Md. (Rural)18. Funeral director Dea. Patterson & SonAddress Perryville, Md.19. Feb. 15, 1945 - Dee. 2. Daugh. Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... HarfordCity or town..... Hayre De Grace
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (u) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1945 st. 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 11 1945 to Feb. 12 1945and that I last saw h. alive on Feb. 12 1945

Immediate cause of death

Acute Delation of Heart

DURATION

2 hrDue to chronic Valvular
Heart Disease10 yr

Due to.....

Other conditions

Md.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. F. MagrueM. D. or other Perryville Md. Date signed 2/14/45
Address

RECEIVED BY THE UNITED STATES GOVERNMENT

AS FROM STANFORD

RECEIVED

MAR 5 1945

BUREAU

PLEASE WRITE PLAINLY, WITH ~~INK~~ INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01616

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

CECIL

County

PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs. 2 mo. 19 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

3. (a) FULL NAME

THOMAS J. KENNEDY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

Single

7. Birth date of deceased (mo., day, yr.)

January 8, 1892

6. (c) If alive, give age years

8. AGE:

Years
53Months
1Days
18It less than one day
- hrs. - min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

P

FATHER

Name

Unknown

13. Birthplace

Unknown

MOTHER

Name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

3-1-1945

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Md.

18. Funeral director

Pennington & Son

Address: Havre de Grace, Md.

19. Date rec'd by registrar

19. 8-15-1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Unknown

County

No permanent residence

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 26

19. 45, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 7, 1924, to Feb. 26, 1945.

and that I last saw him alive on February 26, 1945.

Immediate cause of death
Coronary Occlusion

DURATION

3 da.

Due to Coronary Arteriosclerosis Over 1 yr.

Due to

Other conditions Dementia Precox, Paranoid Over 20 yrs.

yrs.

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

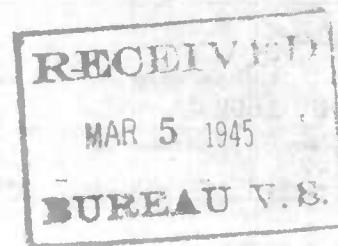
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE
HOLLINGER, Lt. Col., M.C., Clinical or other
Veterans Administration
Address: Perry Point, Md.

Date signed 2-28-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01617

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

Elvinston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louis Josiah Knotts

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Married

6. (b) Name of husband or wife

Alicia Knotts

7. Birth date of deceased (mo., day, yr.)

June 17, 1900

8. (c) If alive, give age

37

years

8. AGE:

Years

Months

Days

If less than one day

44

7

15

hrs.

min.

9. Birthplace

Ridgely, Md.

(Town, county, and state)

10. Usual occupation

Foreman, Warehouse

11. Industry or business

Triumph Explosives

MOTHER FATHER

12. Name

Louis Knotts

13. Birthplace

Ridgely, Md.

14. Maiden name

Agnes Lynch

15. Birthplace

Ridgely, Md.

16. Informant

Mrs. Alicia Knotts

Address

Denton, Md.

17. Burial

Date thereof Feb 3, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Holy Cross

Location

Near Denton, Maryland

18. Funeral director

H. W. Pippin

Address

Elkton, Md.

19. Date rec'd by registrar

Feb 2, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D

County

Dentor

City or town

Denton

Street No.

Denton

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

215-03-0115

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 1, 1945, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

19.

and that I last saw h. alive on

19.

Immediate cause of death

Coronary

Hemorrhage

Due to

DURATION

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Ole Dodson, M.D., Medical Examiner of Cecil County

M. D. or other

Resin & Gun Mt. Date signed 2-1-45

Address

RECEIVED
FEB 15 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01618

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH: *Cecil*
 County: *Cecil*
 City or town: *Cecil*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, Institution, or street address where death occurred: *Union Hospital*

How long in hospital or institution? *2 days*

3. (a) FULL NAME

Miss Edna Howard Lee

3. (b) Social Security Number

4. Sex: *71* 5. Color or race: *white* 6. (a) Single, married, widowed, or divorced: *Single*

B. (b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.): *DEC 6 1883* B. (c) If alive, give age: _____ years8. AGE:

Years: <i>61</i>	Months: <i>2</i>	Days: <i>12</i>	If less than one day: _____
		hrs. _____ min. _____	

9. Birthplace: *Cecil Md* (Town, county, and state)10. Usual occupation: *Housewife*

11. Industry or business: _____

12. Name of father: *John J. Lee*13. Birthplace: *Cecil Co Md*14. Maiden name: *Laura Howard*15. Birthplace: *Cecil Md*16. Informant: *Mrs Helen Walls Wright*Address: *Ocean City Md*17. Burial, cremation, or removal. Which? *Burial* Date thereof: *Feb 21 1945* (month) (day) (year)Cemetery or crematory: *Presbyterian Cem*Location: *Cecil Md*18. Funeral director: *P. J. Jones*Address: *Greenville Md*19. Date rec'd by registrar: *Feb 19 1945* *J. R. Frager* Registrar
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: *Maryland* County: *Cecil*
 City or town: *Cecil*
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *207 N. Main St.*
 (If rural, give LOCATION)

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 18 1945, st 9⁵⁵ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16 1945 to *Feb 17 1945* and that I last saw her alive on *Feb 17 1945*Immediate cause of death: *Cerebral hemorrhage*

DURATION

2 days

Due to: _____

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

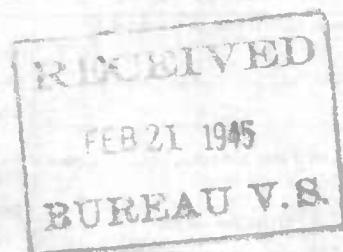
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury: _____

Injured at work? _____

23. SIGNATURE *P. J. Morrison, M.D.* M. D. *Frager*Address: *Cecil Md* Date signed: *Feb 18 1945*



PLEASE WRITE PLAINLY, WITH ~~CO~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *93d*

CERTIFICATE OF DEATH

01619

Reg. Dist. No. *92*

1. PLACE OF DEATH: *Ogil*
 County *Elkton, Md.*
 City or town *(If outside city or town limits, write RURAL and give nearest town)*
 How long in above place of death? *40 years*
 Hospital, Institution, or street address where death occurred: *Union Hospital*
 How long in hospital or institution? *3 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Ogil*
 City or town *Elkton, Md.* *(If outside city or town limits, write RURAL and give nearest town)*
 Street No. *Hugh St.* *(If rural, give LOCATION)*

2.(a) If veteran, name war

3. (a) FULL NAME

W. Cleam Drayton

4. Sex *M.* 5. Color or race *Wh.* 6.(a) Single, married, widowed, or divorced *Widowed.*

6.(b) Name of husband or wife *No Spf.*

7. Birth date of deceased (mo., day, yr.) *No Day* 8.(c) If alive, give age *1870* years

8. AGE: *75* Years *0* Months *0* Days *0* If less than one day *hrs. 0* min.

9. Birthplace *Perma* (Town, county, and state)

10. Usual occupation *at Home*

11. Industry or business

MOTHER FATHER *No Spf.* *No Spf.*

14. Maiden name *No Spf.*

15. Birthplace *No Spf.*

16. Informant *Hospital Records*
 Address *Union Hosp. Elkton, Md.*

17. Burial *Burial* Date thereof *Feb. 14/45*
 (Burial, cremation, or removal. Which?) *(month) (day) (year)*

Cemetery or crematory *Elkton*

Location *Elkton, Md.*

18. Funeral director *H. H. Papers*
 Address *Elkton, Md.*

19. *Feb 14 1945*
 (Date rec'd by registrar) *HB Frazee*
 Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 12* 1945 at 6 *10* a.m.

21. I CERTIFY that death occurred on the date above stated, that *he* attended deceased from *Feb. 11* 1945 to *Feb. 12* 1945 and that I last saw *he* in *alive* on *Feb. 11* 1945

Immediate cause of death

Auto Heart Failure

Due to

*Chronic Myocarditis.**Cause or Duration: not stated.*

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

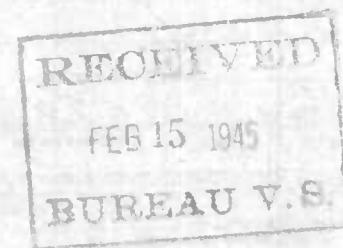
Injured at work?

23. SIGNATURE *Orford H. Sprecher*

M. D. or other

Address *Elkton, Md.* Date signed *Feb. 15*

RECEIVED IN THE UNITED STATES GOVERNMENT



M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4620

01620

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... CecilCity or town..... Bainbridge, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11 Days.Hospital, institution, or street address where death occurred: US Naval Hospital, NavTraCenter, Bainbridge, Md.

How long in hospital or institution?.....

3. (a) FULL NAME

Edward (None) McGHEE4. Sex..... Male 5. Color or race..... Colored 6. (a) Single, married, widowed, or divorced..... Single.8. (b) Name of husband or wife..... not married7. Birth date of deceased (mo., day, yr.)..... 4-23-26 8. (c) If alive, give age..... years8. AGE: Years..... 18 Months..... 9 Days..... 24 If less than one day..... hrs..... min.....9. Birthplace..... Andalusia, Alabama
(Town, county, and state)10. Usual occupation..... US Navy

11. Industry or business

12. Name..... Eddie McGHEE13. Birthplace..... Unknown14. Maiden name..... Unknown15. Birthplace..... Unknown16. Informant..... US Naval Hospital, NavTraCenterAddress..... Bainbridge, Maryland.17. Removal
(Burial, cremation, or removal. Which?)Date thereof..... Feb. 19, 45
(month) (day) (year)

Cemetery or crematory

Location..... 3. Andalusia, Alabama18. Funeral director..... Lee A. Patterson & Son

Address

Perryville, Md.19. Feb. 19, 1945 - June E. Daugherty
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Alabama County.....City or town..... Andalusia
(If outside city or town limits, write RURAL and give nearest town)Street No..... 200 Attic Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... WORLD WAR II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 17 February, 1945 19..... 2:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Feb 1945 (2:45PM) 19..... to 17 Feb 1945 (2:55PM)and that I last saw h. i.m. alive on 17 February, 1945 19.....

Immediate cause of death.....

CARCINOMA, STOMACH

DURATION

Undet

Disease.....

Disease.....

Other conditions Hemorrhage, gastric

6 hours

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy result..... Carcinoma of stomach, metastasis, hemorrhage.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

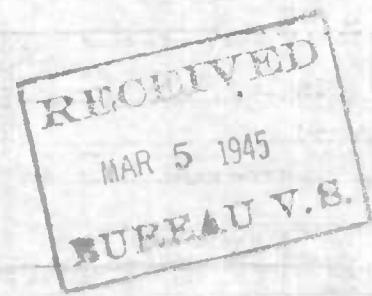
Harry S. Levine, M.D.

Injured at work?

Harry S. Levine, M.D.23. SIGNATURE..... Naval Hospital, Bainbridge, Md. M. D. or otherDate signed..... 2/17/45

RECEIVED IN THE LIBRARY OF THE STATE DEPARTMENT

RECEIVED IN THE LIBRARY OF THE STATE DEPARTMENT



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

CERTIFICATE OF DEATH

Reg. Dist. No. 91

01621

91

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: *Cecil*City or town: *Chesapeake City*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *St. Luke's nursing home*Hospital, institution, or street address where death occurred: *St. Luke's nursing home 3 months*

How long in hospital or institution?

3. (a) FULL NAME

*Sarah R Miller*4. Sex: *Female* Color or race: *White* 6. (a) Single, married, widowed, or divorced: *Single*6. (b) Name of husband or wife: *—*7. Birth date of deceased (mo., day, yr.): *June 1 1855* 6. (c) If alive, give age: *—* years8. AGE: Years: *84* Months: *8* Days: *3* If less than one day: *—* hrs: *—* min: *—*9. Birthplace: *Union Cecil Co. Md* (Town, county, and state)10. Usual occupation: *none*11. Industry or business: *—*12. Name: *William S. Miller*13. Birthplace: *Md*14. Maiden name: *Jane McCullough*15. Birthplace: *Md*16. Informant: *Mrs. R. C. Simpson*Address: *north East Md*17. Burial: *Burial* Date thereof: *Feb 7 45* (month) (day) (year)Cemetery or crematory: *Union*Location: *Elkton R. R. 45*18. Funeral director: *Joseph A. Haan*Address: *north East Md*19. Date rec'd by registrar: *Feb 7 1945*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: *md*County: *Cecil*City or town: *Elkton*Elevation: *Rural*Street No.: *91*

4

(If rural, give LOCATION)

2. (a) If veteran, name war: *—*

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: *Feb. 4 1945* at *840p*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 29 1944 to *Feb 4 1945*and that I last saw her alive on *Feb 4 1945*Immediate cause of death: *Chronic*DURATION: *8 hrs*Due to: *Cardio Thrombosis*Due to: *Stroke*Other conditions: *—*

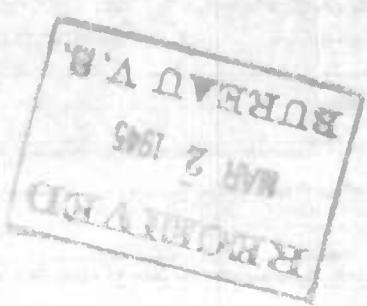
(Include pregnancy within 8 months of death)

Major findings or operations: *—*Date of op: *—*Autopsy results: *—*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: *—* Date of: *—*Where did injury occur? *—* (City or town) *—* (County) *—* (State)Injured at home, farm, industry, public place (where?): *—*Means of injury: *—* Injured at work? *—*23. SIGNATURE: *H. J. Dono* M. D. or other *—*Address: *Chesapeake Dr* Date signed: *Feb 7 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-5)

01622

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County *Cecil*City or town *Elkton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

8 days

3. (a) FULL NAME

Russell Mullins

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. wh. Divorced

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) *March 25, 1905*

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace:

Virginia

(Town, county, and state)

10. Usual occupation:

Writer

11. Industry or business

FATHER

J. M. Mullins

MOTHER

Clintwood, Va

12. Name:

Mattie Rose

13. Birthplace

Grundy, Va

14. Maiden name:

Russell

15. Birthplace

Grundy, Va

16. Informant:

J. R. Mullins

Address

*Frederick, W. Va*17. (Burial, cremation, or removal. Which?) *Burial*Date thereof *March 11, 1945*

(month) (day) (year)

Cemetery or crematory:

Mullins

Location

Elkton, Md.

18. Funeral director:

H. W. Pappas

Address

*Elkton, Md.*19. (Date rec'd by registrar) *Feb 27 1945*

(Date rec'd by registrar)

H. Fraser

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cecil

City or town

Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

229-12-6690

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 26 1945

at 2 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

February 18 1945 to *Feb. 26 1945*and that I last saw him alive on *Feb. 26 1945*

Immediate cause of death:

*Heart - Failure*Due to: *Essential hypertension**Cardio-renal disease with**hypertension**and bronchopneumonia.*

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

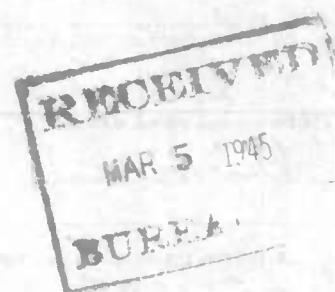
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Dr. Ford W. Creech, M.D.*

M. D. or other

Address *Elkton, Md.* Date signed *Feb.*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

01623

96

Reg. Dist. No.

1. PLACE OF DEATH: Cecil
 County: Cecil
 City or town: Cecil
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 years.
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME

4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Married
 6. (b) Name of husband or wife: Harry L. Murphy Jr.
 7. Birth date of deceased (mo., day, yr.): March 24, 1877 8. (c) If alive, give age: 80 years
 8. AGE: Years: 67 Months: 10 Days: 25 If less than one day: hrs. 00 min. 00
 9. Birthplace: Cecil Co. Md. (Town, county, and state)
 10. Usual occupation: House Wife

11. Industry or business

12. Name: Henry H. Neasey
 13. Birthplace: Cecil Co. Md.
 14. Maiden name: Sarah B. Lynch
 15. Birthplace: Blackbird, Dela.
 16. Informant: Mary L. Murphy Jr.
 Address: Cecil, Md.

17. Burial: Burial Date thereof: Feb 21, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory: West Nottingham
 Location: Cecil, Md. Rural
 18. Funeral director: Lee & Patterson & Son
 Address: Gerrville, Md.
 19. Date rec'd by registrar: Feb 21, 1945 Name: Doris E. Rangert
 (Date rec'd by registrar) (Signature) (Address)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Cecil
 City or town: Cecil
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.:
 (If rural, give LOCATION)
 2.(a) If veteran, name war: _____

3. (b) Social Security Number: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 18, 1945 at 5:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9, 45 to Feb 15, 1945
 and that I last saw her alive on Feb. 15 1945.
 Immediate cause of death: Chronic Myocarditis
 Due to: Chronic Arthritis DURATION: 5 yrs
 Due to: Chronic Arthritis DURATION: 5 yrs
 Due to: _____
 Other conditions: _____

(Include pregnancy within 8 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

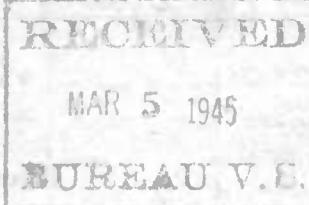
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) _____

Means of injury: _____

Injured at work? _____

23. SIGNATURE: B. J. JohnsonM. D. or other: M. D.Address: Post Debutard Date signed: Feb 21, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 306

01624

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

Cecil

County

Veterans Administration, Perry Point, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 8 mo. 23 days.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

3. (a) FULL NAME

JOHN H. OAKLEY

4. Sex

5. Color or race

Male Negro

6.(a) Single, married, widowed, or divorced

Single (Widower)

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

3-15-1893

8. (c) If alive, give age years

8. AGE:

Years 51

Months 10

Days 17

If less than one day

- hrs.

- min.

9. Birthplace

Dunnsville, Va.

(Town, county, and state)

10. Usual occupation

Cook

11. Industry or business

FATHER

12. Name

Unknown

MOTHER

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

18. Informant

HOSPITAL RECORDS

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 2-3-1945

(month) (day) (year)

Baltimore National Cemetery

Cemetery or crematory

Location Baltimore, Md. *Mr. Katie Williams*
for Ernest R. of gold

19. Funeral director

Miss Katie R. Williams, 322 N.

Address Schroeder St., Baltimore, Md.

Tat. 3

19 45 June 8 English

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 916 Hillman Street

(If rural, give LOCATION)

2.(a) If veteran, name war W. W. I

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

19 45 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1938, to February 1, 1945,

and that I last saw him alive on February 1, 1945.

Immediate cause of death

Syphilis of Central Nervous System

Meningo-encephalitic Type 5 yrs. 10 mo

plus Myocarditis, chronic, cause

undetermined 6 yrs.

Due to

Other conditions Psychosis - with syphilis

of central nervous system, Meningo- 5 yr. 10

Encephalitic type.

mo.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. TROLLINGER, Lt. Col., M.C. Clinical

Director, Veterans Administration

Address Date Signed 2-1-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01625

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH: Cecil
 County Chesapeake City
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Chesapeake City (If outside city or town limits, write RURAL and give nearest town)
 Street No. Biddle St (If rural, give LOCATION)

3. (a) FULL NAME Elsie O Pierce

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
Henry L Pierce
 6. (b) Name of husband or wife Henry L Pierce

7. Birth date of deceased (mo., day, yr.) Aug 3 1872 6. (c) If alive, give age 75 years

8. AGE: 72 Years 6 Months 4 Days If less than one day hrs. min.

8. Birthplace Chesapeake City Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Benjamin Daugherty

12. Name Benjamin Daugherty
 13. Birthplace London England

MOTHER FATHER 14. Maiden name Malala Stables

15. Birthplace Cecil Co Maryland
Victor L Pierce

16. Informant Chesapeake City Md
 Address Chesapeake City Md

17. Burial Burial Date thereof Feb 10 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethel Cemetery
 Location Chesapeake City Md Rd

18. Funeral director H. C. W. Pierce
 Address Ektow Md

19. Date of death Feb 10 1945 Date rec'd by registrar Feb 10 1945

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945 at 2nd fl M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1943 to Feb 8 1945 and that I last saw her alive on Feb 7 1945

Immediate cause of death Concussion of stomach

Due to

Due to

Other conditions Carcinoma of liver

(Include pregnancy within 8 months of death)

Major findings of operation Duodenal obstruction
gastroenterostomy done Date of op. 1943

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry L. Pierce M. D. or other

Address Chesapeake City Md Date signed 2/9/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

01626

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3.5 yrs.

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Evelyn Rhoades

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widow

8. (b) Name of husband or wife

Mrs. P. Rhoades

Feb. 25 1863

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

James Spear

12. Name

MOTHER FATHER

13. Birthplace

Md.

14. Maiden name

Sarah Ann Pinard

15. Birthplace

Md.

16. Informant

Evelyn Rhoades

Address

Rural Fairville, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

Bethel, Md.

18. Funeral director

Edward Fellows

Address

Millington, Md.

19. (Date rec'd by registrar)

Feb. 28, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 25 1945 at 1:00 PM

21. I certify that death occurred on the date above stated: that deceased from

Hod 1944 to Feb 25 1945

and that I last saw her alive on Feb 25 1945

Immediate cause of death.....

Carcinoma of stomach

Due to.....

Due to.....

Other conditions.....

My rheumatism

DURATION

Several months

2 months

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

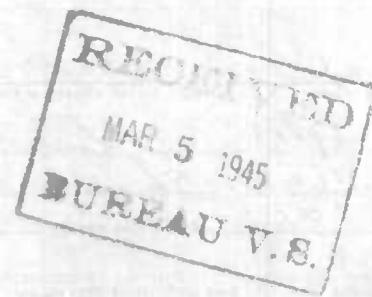
23. SIGNATURE

H. Rhoades M.D. or other

Address: Proprietary, Md. Date signed: Feb. 28, 1945

LETTER TO THE DELEGATE STATE GRASSMAN

MAILED TO THE DELEGATE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

01627

CERTIFICATE OF DEATH

Reg. Dlat. No. 91

1. PLACE OF DEATH:

County *Bethel*
City or town *Bethel*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

1873

8. AGE:

Years	Months	Days	If less than one day
about 79			hrs. min.

9. Birthplace

Collins Beach, Delaware

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Dr. M. P. Richards

12. Name

Dr. M. P. Richards

13. Birthplace

Dr. M. P. Richards

14. Maiden name

Dr. M. P. Richards

15. Birthplace

Dr. M. P. Richards

16. Informant

Dr. M. P. Richards

Address

Dr. M. P. Richards

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Dr. M. P. Richards

Location

Dr. M. P. Richards

18. Funeral director

Dr. M. P. Richards

Address

Dr. M. P. Richards

19. Date rec'd by registrar

February 27, 1945

Date signed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 27, 1945, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1934 to February 1945

and that I last saw her alive on February 24, 1945.

Immediate cause of death

Acute myocarditis

Due to

Chronic pelvic inflammatory disease

Due to

3 days

Other conditions

Chronic nephritis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

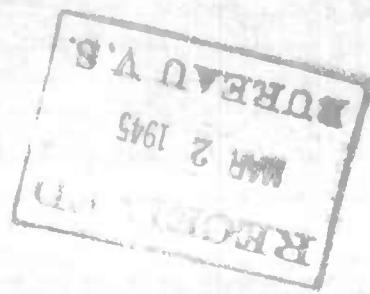
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01628

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Cecil
 City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Union Hospital
Elkton
 How long in hospital or institution? 3 days

3. (a) FULL NAME

James O. Rucker

4. Sex M. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1944 8. (c) If alive, give age years

8. AGE: Years 6 Months 16 Days If less than one day hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Infant

11. Industry or business Chance J. Rucker

12. Name Chance J. Rucker

13. Birthplace Covington, Va.

MOTHER FATHER 14. Maiden name Virginia Eill

15. Birthplace West Va

16. Informant Mr. Ollie Rucker

Address Powell's Apt. Elkton, Md

17. Burial Date thereof Feb 25 45 (Burial, cremation, or removal. When?) (month) (day) (year)

Cemetery or crematory Elkton

Locality Elkton, Md

18. Funeral director J. W. Pippin

Address Elkton, Md

19. Date rec'd by registrar Feb 24, 1945

(Date rec'd by registrar) J. R. Frazer Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil
 City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
 Street No: Water St. Apartment: Powell's Apt.
(If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 01/23

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-20 1945 to 2-23-1945 and that I last saw him alive on Feb. 22 1945

Immediate cause of death: Pneumonia

Due to: Pneumonia DURATION

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

13. SIGNATURE Alv. D. Rucker

M. D. or other
 Address: Elkton, Md Date signed: Feb 23, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

01629

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil

City or town Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death? 13 yrs. 10 mo. 24 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

Now long in hospital or institution? Same as above

3. (a) FULL NAME

ST. CLAIR, Virgil

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age years

May 26, 1894

8. AGE: Years Months Days If less than one day

50 8 20 - hrs. - min.

9. Birthplace Sarfield, Pa.

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Jacob St. Clair

13. Birthplace Unknown

14. Maiden name Anna Litchenfeldt

15. Birthplace Unknown

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal Date thereof 2-15-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grandview Cemetery

Location Johnstown, Pa.

18. Funeral director Pennington & Son

Address Pennington & Son, Havre de Grace, Md.

19. Feb. 15 1945 Deceased A. E. Langford, Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County Cambria

City or town Conemaugh

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Railroad Street

(If rural, give LOCATION)

WW I

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1945 at 9:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1931 to February 15 1945

and that I last saw h. 1m alive on February 15 1945

Immediate cause of death Encephalitis, Lethargica, residuals, Parkinsonian Syndrome Over 13 yrs.

DURATION

Duo to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

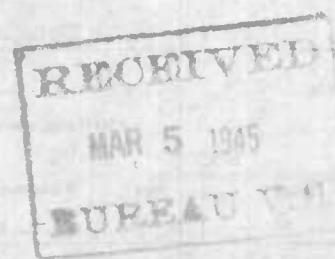
23. SIGNATURE A. E. Langford, Lt. Col., M.C., C.M. and other

Director, Veterans Administration

Address Perry Point, Md. Date signed 2-15-45

MAILED TO TENNESSEE STATE GRASSLANDS

REMAILED TO BROADFIELD



M

MARGIN RESERVED FOR BINDING

1 PLEASE WRITE PLAINLY, WITH ~~INK~~ FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01630

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County

City or town

Cecil
North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

13 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lester Sexton

4. Sex

M

5. Color or race

White Single

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

1899

6. (c) If alive, give age

years

8. AGE:

45

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

N.C.

10. Usual occupation

Laborer.

11. Industry or business

Unknown

12. Name

Unknown

13. Birthplace

N.C.

MOTHER FATHER

Unknown

14. Maiden name

Unknown

15. Birthplace

N.C.

16. Informant

Ralph Thomas

Address

North East, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

West Jefferson N.C.

Location

West Jefferson N.C.

18. Funeral director

Address

Krisin Sun Md.

19.

1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

11

County

Cecil

City or town

Lawn

Lawn

Cecil

Street No.

1

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 24 1945 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Acute
Alcoholism

DURATION

One to

One to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

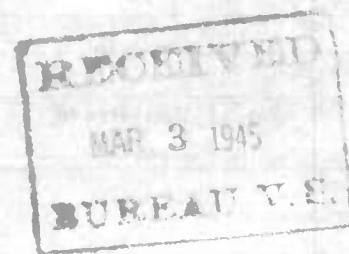
Signature

M. D. or other

Address

Date signed

Le Dodsorff
Cecil County
Alma 9 Sun 1945



PLEASE WRITE PLAINLY, WITH
BLACK FADING INK. Supply every item of information carefully. The correct
percentage
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

01631

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Civil.
County: Elkton Md.

City or town: Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65

Hospital, Institution, or street address where death occurred: Elkton, Md.

How long in hospital or institution?

3. (a) FULL NAME Eva Mae Shaffer

4. Sex F. 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Henry Shaffer

7. Birth date of deceased (mo., day, yr.) April 16, 1879 8. (c) If alive, give age 65 years

8. AGE: 65 Years 10 Months 18 Days It less than one day hrs. 0 min.

9. Birthplace Elkton, Md. (Town, county, and state)

10. Usual occupation at home

11. Industry or business Joseph Cridon

FATHER 12. Name Joseph Cridon
13. Birthplace Elkton, Md.

MOTHER 14. Maiden name No Information

15. Birthplace Wilmington, Del.

16. Informant Lewis Chase

Address Wilmington, Del.

17. Burial Burial Date thereof Feb 6, 1945
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md.

18. Funeral director H. W. Tupper

Address Elkton, Md.

19. Date rec'd by registrar Feb 6, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Elkton

City or town Elkton Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1945 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1944 to Feb 3, 1945 and that I last saw her alive on December 30, 1944

Immediate cause of death Heart Coronary Occlusion DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Dr. T. Morrison, M.D.

M. D. 2-5-45

Address Elkton, Md. Date signed 2-5-45

AMERICAN STAFF BRIGADE

RECEIVED BY MAIL

RECEIVED
FEB 15 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, IN UNPADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

01632

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

Elkton - Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital 7th

How long in hospital or institution?

3. (a) FULL NAME

Rhoda Scopes

4. Sex

female

5. Color or race

black

6. (a) Single, married, widowed, or divorced

widowed

B. (b) Name of husband or wife

Jos Simpers & John Conner

7. Birth date of deceased (mo., day, yr.)

June 22, 1882

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

62

8

24

hrs. min.

9. Birthplace

Elkton - Cecile Ho - Md

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

Henry Johnson

FATHER

12. Name

North East - Ind

13. Birthplace

Rachael Wright

MOTHER

14. Maiden name

North East - Ind

15. Birthplace

Elizabeth Simpers - col

16. Informant

Elkton Md.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Providence Cemetery Elkton

Location

Elkton Md.

Funeral director

Foster Bell

Address

909 Byslair St Wil Ode

Feb 19 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecile

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Collins St

(If rural, give LOCATION)

2.(d) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 17

1945

at 12.55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16 - 1945, to Feb 17 1945

and that I last saw her alive on Feb 16 1945

Immediate cause of death

Hypnotic coma

DURATION

24 hrs

Due to

Due to

Other condition

Influenza -

13 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

T. H. McKnight M.D.

M. D. or other

Address

Elkton - Md

Date signed

Registrar

Feb 17 1945

STJACH TO THE INTERSTATE STATE CHARTER

STJACH TO STADIUM INC



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01633

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County Cecil

City or town Veterans Administration, Perry Point, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 5 mo. 4 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above.

3. (a) FULL NAME

SMITH, Arthur W.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower

B. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.) July 19, 1892

8. AGE: Years Months Days It less than one day
52 6 25 - - hrs. - min.

9. Birthplace Tilghman, Talbot Co., Md.

(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal Date thereof 2-14-45
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oak Lawn Cemetery

Location Baltimore, Md.

18. Funeral director R. M. Madison Mitchell
mitchell Funeral Home

Address Baltimore, Md. 1900 Eutaw Place

19. Date rec'd by Registrar 2/14/45 Jane E. Daugherty
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Tilghman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1945 at 3:54 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 9 1941 to February 13 1945 and that I last saw him alive on February 13 1945.

Immediate cause of death

Tuberculosis, pulmonary, bilateral

Undetermined

DURATION

Due to

Due to

Other conditions Psychosis with Paralysis Agitans (Parkinson's Disease) Over 5 years
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

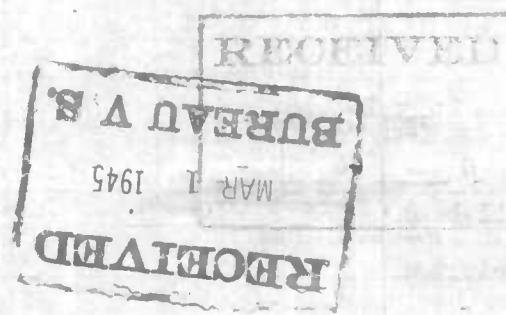
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE
R. E. REESEWIGER
LIEUTENANT, LT. COL., M.C., Clinical Director,
Veterans Administration
Address Perry Point, Md. Date signed 2-14-45



PLEASE WRITE PLAINLY, WITH DARK ADADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

01634

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

Cecil

County

Perry Point, Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

1 yr. 2 mo. 12 days

How long is above place of death?

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution?

Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 510 -5th Street, N.W., Wash., D.C.

(If rural, give LOCATION)

Spanish American

2.(a) If veteran, name war

3. (a) FULL NAME

SNEE, Thomas A.

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widower

6.(b) Name of husband or wife

Unknown

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

April 18, 1859

8. AGE:

Years

Months

Days

If less than one day

85

10

1

m.

hrs.

m.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

Unknown

11. Industry or business

-

MOTHER

FATHER

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Hospital Records

Address

Veterans Administration, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Arlington National Cemetery

Cemetery or crematory

Arlington, Va.

18. Funeral director

Pennington & Son

Address Havre de Grace, Md.

19. Date rec'd by registrar

19. 85

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 19 1945 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 7, 1943, to Feb. 19, 1945,

and that I last saw h. i.m. alive on February 19, 1945.

Immediate cause of death

Myocardial Insufficiency Over 14 months

DURATION

Due to Myocardial Damage " 14 months

months

Due to Coronary Arteriosclerosis Over 14 mos.

months

Other conditions Psychosis, Senile. With

Simple Deterioration Over 14 mos.

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

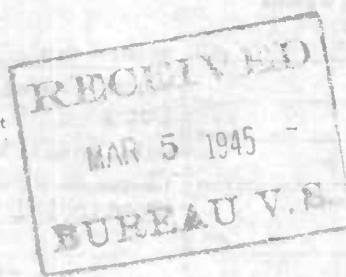
23. SIGNATURE

Lt. Col. M.C. Climber

Other

Director, Veterans Administration

Address Perry Point, Md. Date signed 2-19-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

01635

CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

9 mos.

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

Stanley Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

3. (a) FULL NAME

Charles E. Williams

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age.....

years

May

1863

8. AGE: Years

Months

Days

If less than one day

81

hrs.

min.

9. Birthplace.....

Cecil co. md.

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

12. Name.....

MOTHER

FATHER

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial (Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 3, 1945, to Feb. 20, 1945

and that I last saw him alive on Feb. 20, 1945

Immediate cause of death.....

Chronic Myocarditis

Due to.....

Due to.....

Other conditions.....

Arterio-Sclerotic Central Hemorrhage

(Include pregnancy within 8 months of death)

Major findings of operations.....

Data of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Date signed.....

RECEIVED
MAR 5 1945
BUREAU V.S.

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

01636

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

Cecil County

Perry Point, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

17 yrs. 5 mo. 23 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution?

Same as above

3. (a) FULL NAME

WOBLAWSKI, Jan

4. Sex

Male White 6.(a) Single, married, widowed, or divorced
Single

8.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1897

8. AGE: Years Months Days If less than one day
47 9 20 - - - -9. Birthplace Randise, Russia
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business Unknown

12. Name John Wablawski

13. Birthplace Russia

14. Maiden name Unknown

15. Birthplace Russia

16. Informant Hospital Records

Address Veterans Administration, Perry Point,

17. Removal Date thereof Feb. 2, 1945
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Erie Cemetery

Location Erie, Pa.

18. Funeral director

Address Howard Grace M.

19. Feb. 2, 1945, Irene E. Daugherty

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Pennsylvania County Erie

City or town Erie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1325 German Street

(If rural, give LOCATION)

W.W. I

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1945 5:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 9 1927 to February 1 1945

and that I last saw him alive on February 1 1945.

Immediate cause of death

Tuberculosis, pulmonary, chronic far advanced, active

DURATION

3 months

Due to

Due to

Other conditions Dementia Precox, Hebephrenic

Type over 17 yrs.

(Include pregnancy within 8 months of death)

Major findings or operations None performed

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

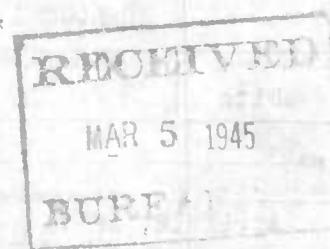
Means of injury Injured at work?

23. SIGNATURE

TROLLINGER, Lt. Col. M.C., Clinical or Director

Veterans Administration Perry Point, Md.

Date signed 2-2-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *78A*

CERTIFICATE OF DEATH

01637
Reg. Dist. No. 96

1. PLACE OF DEATH:

County **Cecil**City or town **Elkton**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Union HospitalHow long in hospital or institution? **2 days**

3. (a) FULL NAME

James Walton WOODWARD

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
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6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) **8-17-24** 8. (c) If alive, give age years8. AGE: Years **20** Months **6** Days **4** If less than one day hrs. min.9. Birthplace **Williston, S.C.** (Town, county, and state)10. Usual occupation **U. S. Navy**

11. Industry or business

12. Name **John Richard Woodward**13. Birthplace **Barnwell County, S.C.**14. Maiden name **Lottie May Hair**15. Birthplace **Blackville, S.C.**16. Informant **John Richard Woodward Jr.**Address **Jesup, Georgia**17. Removal Date thereof **Feb 26 1945** (Burial, cremation, or removal where?) (month) (day) (year) Cemetery or crematory **John Folk Funeral Home**Location **Williston, South Carolina**18. Funeral director **Vee a. Patterson & Son**Address **Terryville, Md.**19. Date rec'd by registrar **Feb. 26 1945** Date of death **Jan. 26 1945** Registrar **June E. Daugherty**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **S.C.** County **Barnwell**City or town **Williston** (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war **World War II**

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH **21 February** 19. 45 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Bilateral pneumoniaDue to **Carbon monoxide poisoning**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operationa

Date of op.

Autopsy results **Yes. Above findings**

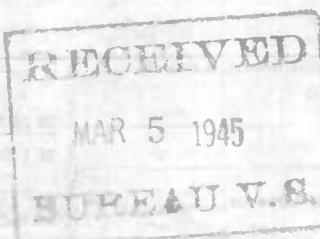
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Accident** Date of **2-19-45**Where did injury occur? **Elkton** (City or town) **Cecil** (County) **Md.** (State) **Home**

Injured at home, farm, industry, public place (where?)

Means of injury **Gas heater** Injured at work?23. SIGNATURE **John Richard Woodward** Medical Examiner **Cecil County** M. D. or otherAddress **Youngsboro, Md.** Date signed **Feb. 26 1945**



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01638

96

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

CECIL
County

City or town PERRY POINT, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

7 yrs, 10 mo. 11 days.

How long in above place of death?

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

3. (a) FULL NAME

YOUNG, Walter Douglas

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Mrs. Gertrude (E.)
Maiden name unknown

7. Birth date of deceased (mo., day, yr.) June 27, 1870

8. AGE: Years	Months	Days	If less than one day
74	7	29 hrs. min.

9. Birthplace Auburn, New York
(Town, county, and state)

10. Usual occupation Electrical Engineer

11. Industry or business

12. Name	Unknown
13. Birthplace	Unknown

14. Maiden name	Unknown
15. Birthplace	Unknown

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal Date thereof 2-26-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

LOUDON PARK CEMETERY

Location Baltimore, Md.

18. Funeral director Harry S. Witzke, per C.E.W.
Address 1401 Edmondson Ave., Balto., Md.

19. Feb. 26, 1945 Irene E. Langford A.
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 425 E. Hamburg St.,

(If rural, give LOCATION)
W.W. I

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1945 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14 1945 to Feb. 25 1945.

and that I last saw him alive on February 25 1945.

Immediate cause of death Myocardial Insufficiency

DURATION

Over 4 yrs.

Due to Myocarditis, chronic Over 4 yrs.

Due to

Involutional Melancholia Over 7 yrs.

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE TROLLINGER, Lt. Col. M.C. Clinical or other
Director, Veterans Administration

Address Perry Point, Md. Date signed Feb. 26, 1945

